PATIENT MEDICAL HISTORY

PATIENT NAME:_____ DATE OF BIRTH:_____

PHYSICIAN'S NAME:_____ PHYSICIAN'S PHONE:_____

Medical Alerts: _____

Medications: Specify the name of each medication you are taking and it's purpose including non-prescription.

_____

_____

PLEASE ANSWER ALL OF THE QUESTIONS **YES** OR **NO** AND PROVIDE ANSWERS WHERE APPLICABLE:

YES NO Do you consider yourself to be in good health?
YES NO Are you now or have you been under a physician's care within the last 2 years?
IF YES, specify condition being treated:_____
YES NO Do you have or have you ever had any heart or blood problems?
YES NO Have you ever been told that you have a heart murmur?
YES NO Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint?
YES NO Do you have or have you ever had high blood pressure?
YES NO Do you bruise easily or have had excessive bleeding requiring special treatment?

YES NO Have you ever been diagnosed as being HIV positive or having AIDS?
YES NO Have you ever had hepatitis A or B or liver disease?
YES NO Have you ever received counseling or undergone psychiatric treatment?
YES NO Have you ever received counseling for use of alcohol and/or prescription drugs?

YES NO Are you subject to fainting?
YES NO Are you now in pain?
YES NO Have you ever taken Phen-Fen or similar appetite suppressants?
YES NO **IF YES**, have you seen your physician or cardiologist for a cardiac evaluation?
YES NO Have you ever taken Fosamax, Actonel, Boniva, or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer?

Circle any of the following you have ever used or are using now:

tobacco alcohol cocaine Other: _____

Circle any conditions you have/had:

asthma	tuberculosis	any blood disorder	immune system disorders
arthritis	rheumatism	rheumatic fever	sexually transmitted disease
diabetes	heart attack	kidney disease	Other: _____

Circle any of the following drugs you are allergic to or have had an unusual reaction to:

aspirin	ibuprofen	sulfa drugs	penicillin or other antibiotics
iodine	sedatives	barbiturates	acetaminophen
codeine			Other: _____

YES NO Have you ever had a severe reaction to or are you allergic to any local anesthetic?
YES NO Do you have any other allergies including skin reactions to non-gold jewelry?
IF YES, please describe:_____
YES NO **Women:** Are you pregnant or think you may be pregnant?
YES NO **Women:** Are you nursing?

Please complete the reverse side

PATIENT DENTAL HISTORY

When was the last time you had a dental checkup and cleaning?_____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

What other dental aids do you use such as mouthwash, interproximal brushes etc. ?_____

YES NO Are you comfortable having dental treatment?
YES NO Have you ever had an unpleasant experience in a dental office?
YES NO Have you ever had any severe reactions to dental treatment?
YES NO Have you ever had any difficult extractions in the past?

YES NO Do you feel pain in any of your teeth?
YES NO Are your teeth sensitive to hot or cold liquids/foods?
YES NO Are your teeth sensitive to sweet or sour liquids/foods?
YES NO Do your gums bleed while brushing or flossing?
YES NO Do you have any sores or lumps in or near your mouth?

YES NO Have you had any head, neck or jaw injuries?
YES NO Have you ever experienced any clicking or pain in your jaw?
YES NO Do you have frequent headaches?
YES NO Do you clench or grind your teeth?
YES NO Do you frequently bite your lips or cheeks?

YES NO Have you had any orthodontic work?

YES NO Have you ever had instruction on the correct method of brushing your teeth?
YES NO Have you ever had instruction on the care of your gums?

YES NO Have you ever been diagnosed and/or treated for periodontal disease?

YES NO Are you satisfied with the appearance of your teeth?
IF NO, what would you change about your smile?_____

Please explain anything else you would like us to know regarding your medical or dental health:_____
_____

I hereby certify that the answers to the foregoing questions are accurate to the best of my ability. Since a change in my medical/dental condition or in medications I take can affect dental treatment, I understand the importance of and agree to take the responsibility to notify the dentist of any changes at any subsequent appointment.

Signature _____ Date _____
(Patient, legal guardian or authorized agent of patient)

Medical/Dental Changes _____

Signature _____ Date _____
(Patient, legal guardian or authorized agent of patient)

Medical/Dental Changes _____

Signature _____ Date _____
(Patient, legal guardian or authorized agent of patient)

Medical/Dental Changes _____

Signature _____ Date _____
(Patient, legal guardian or authorized agent of patient)